Mark Antoine Foster, In Pro Per
200 Corpus Cristie Road #A
Alameda, California 94502
(415) 756-1611
(619) 646-3564

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

MARK ANTOINE FOSTER,

Plaintiff,

vs.

MORGAN LEWIS and BOKIUS, and ERIC MECKLEY, an individual and DOES 1 Through 81

Defendants

/

Case No. **C-08- 01337 MHP**

DECLARATION OF MARK ANTOINE FOSTER IN SUPPORT THEREOF AND EXHIBITS 1 THRU 6 ATTACHED THERETO

Date: April 28, 2008
Time: 2:00 p.m.

I MARK ANTOINE FOSTER declare that:

1. I am the plaintiff in this action and have personal knowledge of each fact stated in the complaint filed against Aramark Sports LLC, and Aramark Corporation , a parties to this action.

2. Attached hereto as Exhibit 1 and incorporated herein by reference is pages 11, 1, and exhibit 6 of Aramark and Defendant Attorney Meckley's Early Settlement

Conference Statement.

3. Attached hereto as Exhibit 2 and incorporated herein by reference is the Voluntary Resignation Agreement Plaintiff signed on March 28, 2006.

4. Attached hereto as Exhibit 3 and incorporated herein by reference is page 6 of Aramark Sports LLC's answers to Plaintiff's Employment Interrogatories.

5. Attached hereto as Exhibit 4 and incorporated herein by reference is copies of Plaintiff State Disability payment check stubs.

6. Attached hereto as Exhibit 5 and incorporated herein by reference is a copy of the compromise and release agreement presented to Plaintiff by the law offices of Gray and Prouty.

7. Attached hereto as Exhibit 6 and incorporated herein by reference is a copy of the new Voluntary Resignation Agreement displaying the May 1, 2007 date.

I declare under penalty under the laws of the state of California that the foregoing is true and correct and that this declaration was executed this day on the 21st of March 2008, at San Francisco, California.

Mark A. Foster

Mark Antoine Foster, In Pro Per

EXHIBIT 1

MORGAN, LEWIS & BOCKIUS LLP
ERIC MECKLEY, State Bar No. 168181
SUZANNE BOAG, State Bar No. 250441
One Market, Spear Street Tower
San Francisco, CA 94105-1126
Tel: 415.442.1000
Fax: 415.442.1001

Attorneys for Defendants
ARAMARK SPORTS, LLC (erroneously sued as ARAMARK Sports and Entertainment), YING KEE McVICKER, and MATTHEW LEE

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UNLIMITED JURISDICTION

MARK ANTOINE FOSTER,

Plaintiff,

vs.

ARAMARK SPORTS & ENTERTAINMENT, Ying Kee McVicker, an individual, Matthew Lee, an individual, and DOES 1 Through 51,

Defendants.

Case No. CGC-07-461178

DEFENDANTS' EARLY SETTLEMENT PROGRAM SETTLEMENT CONFERENCE STATEMENT

Date: January 11, 2008

Action Filed: March 9, 2007
Trial Date: May 19, 2008

TABLE OF CONTENTS

EXHIBIT 6

VOLUNTARY RESIGNATION

I, Mark Foster, voluntarily resign my position with Aramark as of June 15, 2006.

Mark Foster May 7, 2007
Mark Foster, Date

ARA/Fos
D 0177

EXHIBIT 2

CALX # 030647549

LEAVE OF ABSENCE REQUEST

Chief Alfonso called at 11:13am 6/15 to inform me Mark did not show for work He was scheduled to work at 11 am. 6/12

Chief Tim called 3 days ago to inform him he will be on the schedule JC

Employee's Name Mark Antoine Foste

Social Security Number 302-56-8205

Hire Date 9/8/05 Unit K9

Request Leave of Absence

To Start March 30, 2006
no later than
To Return JUNE 15, 2006

To Be Read And Signed By Employee:

I understand that failure to report to work at the date specified above means that I am quitting voluntarily and I will, therefore, be terminated on that day.

Mark A. Foste
Employee's Signature

Reason for Request

Emotional Stress, mental anguish

Mark A. Foste
Employee's Signature

March 28, 2006
Date

APPROVALS:

Department Head _____ Date 3/28/06

Controller _____ Date 3/28/06

Personnel _____ Date

EMPLOYEE NOTIFIED OF DECISION ON 3/29/06

EXHIBIT 3

MORGAN, LEWIS & BOCKIUS LLP
ERIC MECKLEY, State Bar No. 168181
SUZANNE BOAG, State Bar No. 250441
One Market, Spear Street Tower
San Francisco, CA 94105-1126
Tel: 415.442.1000
Fax: 415.442.1001

Attorneys for Defendants
ARAMARK SPORTS, LLC (erroneously sued as ARAMARK Sports and Entertainment), YING KEE McVICKER, and MATTHEW LEE

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

UNLIMITED JURISDICTION

MARK ANTOINE FOSTER, Plaintiff, vs. ARAMARK SPORTS & ENTERTAINMENT, Ying Kee McVicker, an individual, Matthew Lee, an individual, and DOES 1 Through 51, Defendants.	Case No. CGC-07-461178 **DEFENDANT ARAMARK SPORTS, LLC'S RESPONSE TO PLAINTIFF'S FORM INTERROGATORIES – EMPLOYMENT LAW (SET ONE)** Action Filed: March 9, 2007 Trial Date: May 19, 2008

PROPOUNDING PARTY: Plaintiff, MARK ANTOINE FOSTER

RESPONDING PARTY: Defendant, ARAMARK SPORTS, LLC

SET NUMBER: ONE (1)

RESPONSES TO FORM INTERROGATORIES

INTERROGATORY NO. 200.1:

Do you contend that the **EMPLOYMENT** relationship was "at will"? If so:

(a) state all facts upon which you base this contention;

(b) state the name, **ADDRESS**, and telephone number of each **PERSON** who has knowledge of those facts; and

Defendant objects to this Interrogatory on the grounds that the phrase "involved in a TERMINATION" is vague and ambiguous. Defendant further objects to this Interrogatory on the grounds that it is overbroad. Notwithstanding and without waiving such the foregoing objections, Defendant responds: Plaintiff elected to terminate his employment.

(a) Plaintiff voluntarily resigned by electing not to return from a leave of absence. Defendant did not terminate the Plaintiff.

(b) Because Plaintiff voluntarily resigned, Defendant believes Plaintiff was likely the only person who participated in his decision to resign.

(c) This sub-part does not appear applicable given the fact that Plaintiff voluntarily resigned, and Defendant did not terminate him.

(d) Defendant lacks knowledge or information as to what documents, if any, Plaintiff relied upon in deciding to voluntarily resign. Plaintiff signed an agreement on March 28, 2005 which stated that if he did not report to work following his leave of absence by June 15, 2005, then he would be considered to have voluntarily resigned.

INTERROGATORY NO. 201.2

Are there any facts that would support the **EMPLOYEE'S TERMINATION** that were first discovered after the **TERMINATION**? If so:

(a) state the specific facts;

(b) state when and how **EMPLOYER** first learned of each specific fact;

(c) state the name, **ADDRESS**, and telephone number of each **PERSON** who has knowledge of the specific facts; and

(d) identify all **DOCUMENTS** that evidence these specific facts.

RESPONSE TO INTERROGATORY NO. 201.2:

To the extent this Interrogatory seeks evidence pertaining to "after-acquired evidence" which would support an involuntary termination, Defendant responds: Defendant did not involuntarily terminate Plaintiff; rather, Plaintiff voluntarily resigned. In any event, Defendant has become aware during the course of its investigation that Plaintiff falsified his employment application by indicating that he had never been convicted of a felony, when in fact he was

EXHIBIT 4

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 07/15/06
SSN: 302-56-8205 NAME: MARK A . OSTER **CLAIM EFFECTIVE DATE: 03/30/06**
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

IF YOU ARE NOT PAID FOR ANY DAYS, YOU WILL BE NOTIFIED WHAT DAYS WERE NOT PAID AND WHY THEY WERE NOT PAID IN THE MESSAGE AREA BELOW. THE OFFICE PROCESSING YOUR CLAIM IS:

EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 06/04/06 THROUGH 07/13/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
40	$1897.14	$0.00	$1897.14

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL

DATE ISSUED 05/25/06

SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAIT[illegible] PERIOD, YOU WILL BE PAID FOR EVERY DA[illegible]OU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

IF YOU ARE NOT PAID FOR ANY DAYS, YOU WILL BE NOTIFIED WHAT DAYS WERE NOT PAID AND WHY THEY WERE NOT PAID IN THE MESSAGE AREA BELOW. THE OFFICE PROCESSING YOUR CLAIM IS:

EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 05/10/06 THROUGH 05/23/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS REMUEVA ESTE TALON PARA SU RECORD PERSONAL CU PAJ61 (10-04) FLASH

DETACH AND SEE REVERSE SIDE [illegible] DETACH THIS STUB FOR YOUR RECORDS / REMUEVA ESTE TALON PARA SU RECORD PERSONAL

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 06/06/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 05/24/06 THROUGH 06/03/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
11	$521.71	$0.00	$521.71

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

NOTICE OF FINAL PAYMENT

THIS IS YOUR FINAL PAYMENT BECAUSE INFORMATION IN YOUR DISABILITY INSURANCE CLAIM INDICATES THAT YOU ARE NO LONGER DISABLED. IF YOU ARE STILL DISABLED: SEE SUPPLEMENTAL CERTIFICATION. YOU AND YOUR DOCTOR MUST COMPLETE A SUPPLEMENTAL CERTIFICATION FOR YOU TO RECEIVE CONTINUING BENEFITS.

IF YOU ARE UNEMPLOYED AND ABLE TO WORK: REPORT TO THE NEAREST UNEMPLOYMENT INSURANCE OFFICE FOR HELP IN FINDING WORK AND TO DETERMINE YOUR ELIGIBILITY FOR UNEMPLOYMENT INSURANCE BENEFITS.

DE 2525XX REV. 1 (7/96)

DE 2500CKX Rev. (8/03)

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 09/09/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 08/25/06 THROUGH 09/07/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RÉCORD PERSONAL 061 (10-04) FLASH

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 10/07/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

IF YOU ARE NOT PAID FOR ANY DAYS, YOU WILL BE NOTIFIED WHAT DAYS WERE NOT PAID AND WHY THEY WERE NOT PAID IN THE MESSAGE AREA BELOW. THE OFFICE PROCESSING YOUR CLAIM IS:

EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 09/22/06 THROUGH 10/05/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RÉCORD PERSONAL CU PA061 (10/04) FLASH

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 09/23/06

SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 09 08 06 THROUGH 09 21 06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

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YOU HAVE BEEN PAID DISABILITY BENEFITS ON AN AUTOMATIC PAYMENT CYCLE. FOR THE DEPARTMENT TO VERIFY YOUR CONTINUING ELIGIBILITY, COMPLETE AND IMMEDIATELY RETURN THE ENCLOSED DISABILITY CLAIM STATUS QUESTIONNAIRE (DE2593) TO THE DISABILITY OFFICE SHOWN ABOVE.

IF YOU EXPECT YOUR DISABILITY TO BE LONG-TERM, YOU SHOULD CONTACT THE SOCIAL SECURITY INFORMATION LINE AT 1-800-772-1213 TO FIND OUT ABOUT ADDITIONAL BENEFITS THAT MIGHT BE AVAILABLE.

DE 2593-A (12/91)

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RECORD PERSONAL CU PA061 (10/04) FLASH

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 10/21/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534
THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 10/06/06 THROUGH 10/19/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

Oct 19th
3rd Nov
14 days
17 Nov
30th Nov
Nov 6th 664
Nov 20th 664
Dec 4th 664
1,992
1992
1400
3412

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL CUTPAGE (10-04) FLASH

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 11/04/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534
THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 10/20/06 THROUGH 11/02/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RECORD PERSONAL

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 12/02/06

SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 11/17/06 THROUGH 11/30/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

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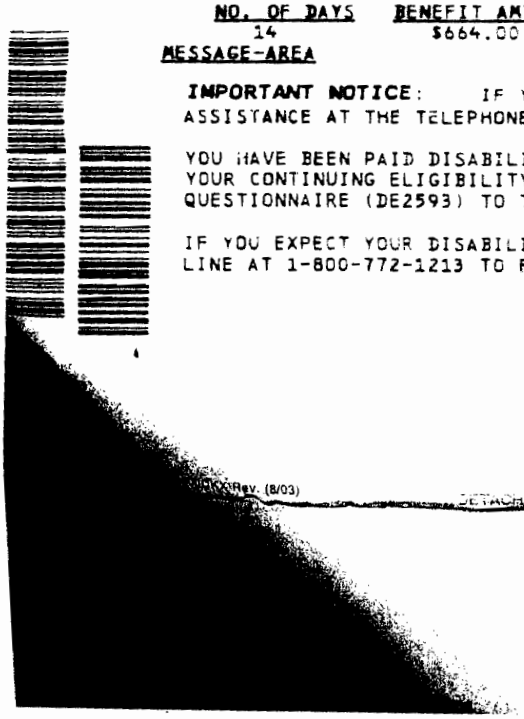
YOU HAVE BEEN PAID DISABILITY BENEFITS ON AN AUTOMATIC PAYMENT CYCLE. FOR THE DEPARTMENT TO VERIFY YOUR CONTINUING ELIGIBILITY, COMPLETE AND IMMEDIATELY RETURN THE ENCLOSED DISABILITY CLAIM STATUS QUESTIONNAIRE (DE2593) TO THE DISABILITY OFFICE SHOWN ABOVE.

IF YOU EXPECT YOUR DISABILITY TO BE LONG-TERM, YOU SHOULD CONTACT THE SOCIAL SECURITY INFORMATION LINE AT 1-800-772-1213 TO FIND OUT ABOUT ADDITIONAL BENEFITS THAT MIGHT BE AVAILABLE.

DE 2593-A (12/91)



Rev. (8/03)

DETACH THIS STUB FOR YOUR RECORDS

DETACH AND SEE REVERSE SIDE — DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL

KEEP THIS STATEMENT FOR YOUR RECORDS.

DATE ISSUED 12/16/06

SSN: 302-56-8205 NAME: MARK A FOSTER

CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 12/01/06 THROUGH 12/14/06.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL CO-PAG61 (10-04) FLASH

DETACH AND SEE REVERSE SIDE — DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL

KEEP THIS STATEMENT FOR YOUR RECORDS.

DATE ISSUED 02/01/07

SSN: 302-56-8205 NAME: MARK A FOSTER

CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 01/26/07 THROUGH 01/30/07.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
5	$237.14	$0.00	$237.14

MESSAGE-AREA

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NOTICE OF FINAL PAYMENT

THIS IS YOUR FINAL PAYMENT BECAUSE INFORMATION IN YOUR DISABILITY INSURANCE CLAIM INDICATES THAT YOU ARE NO LONGER DISABLED. IF YOU ARE STILL DISABLED: SEE SUPPLEMENTAL CERTIFICATION. YOU AND YOUR DOCTOR MUST COMPLETE A SUPPLEMENTAL CERTIFICATION FOR YOU TO RECEIVE CONTINUING BENEFITS.

IF YOU ARE UNEMPLOYED AND ABLE TO WORK: REPORT TO THE NEAREST UNEMPLOYMENT INSURANCE OFFICE FOR HELP IN FINDING WORK AND TO DETERMINE YOUR ELIGIBILITY FOR UNEMPLOYMENT INSURANCE BENEFITS.

DE 2525XX REV. 1 (7/96)

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL CU-PA061 (10-04) FLASH

DETACH AND SEE REVERSE SIDE

KEEP THIS STATEMENT FOR YOUR RECORDS.

DATE ISSUED 01/27/07

SSN: 302-56-8205 NAME: MARK A FOSTER

CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 01/12/07 THROUGH 01/25/07.

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE AREA

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DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL CU-PA061 (10-04) FLASH

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 07/29/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

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EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 07/14/06 THROUGH 07/27/0

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

7/13 7/15
7/27 7/29
8/10 8/12

DE 2500CKX Rev (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RECORD PERSONAL CIV PA061 (10-04) FLAG 1

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 08/12/06
SSN: 302-56-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06
WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS
EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

IF YOU ARE NOT PAID FOR ANY DAYS, YOU WILL BE NOTIFIED WHAT DAYS WERE NOT PAID AND WHY THEY WERE NOT PAID IN THE MESSAGE AREA BELOW. THE OFFICE PROCESSING YOUR CLAIM IS:

EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 07/28/06 THROUGH 08/10/0

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALÓN PARA SU RÉCORD PERSONAL CIV PA061 (10-04) FLAG

KEEP THIS STATEMENT FOR YOUR RECORDS. DATE ISSUED 08/26/06

SSN: 302-58-8205 NAME: MARK A FOSTER CLAIM EFFECTIVE DATE: 03/30/06

WEEKLY RATE: $332.00 WEEKLY RATE IS FOR 7 DAYS

EXCEPT FOR THE MANDATORY 7-DAY WAITING PERIOD, YOU WILL BE PAID FOR EVERY DAY YOU ARE ELIGIBLE FOR BENEFITS, INCLUDING WEEKENDS.

IF YOU ARE NOT PAID FOR ANY DAYS, YOU WILL BE NOTIFIED WHAT DAYS WERE NOT PAID AND WHY THEY WERE NOT PAI IN THE MESSAGE AREA BELOW. THE OFFICE PROCESSING YOUR CLAIM IS:

EMPLOYMENT DEVELOPMENT DEPARTMENT TELEPHONE: (800) 480-3287
P O BOX 193534
SAN FRANCISCO CA 94119-3534

THE ATTACHED CHECK IS FOR STATE DISABILITY INSURANCE FOR THE FOLLOWING PERIOD(S): 08/11/06 THROUGH 08/24/

NO. OF DAYS	BENEFIT AMT.	AMT. DEDUCTED	AMT. PAID
14	$664.00	$0.00	$664.00

MESSAGE-AREA

IMPORTANT NOTICE: IF YOU DO NOT UNDERSTAND ANY FORM SENT TO YOU BY THIS OFFICE, CONTACT US FOR ASSISTANCE AT THE TELEPHONE NUMBER SHOWN ON THE CHECK STATEMENT.

DE 2500CKX Rev. (8/03) DETACH THIS STUB FOR YOUR RECORDS/REMUEVA ESTE TALON PARA SU RECORD PERSONAL CU PA04 110-04LE ASI

EXHIBIT 5

LAW OFFICES OF
GRAY & PROUTY

A PROFESSIONAL CORPORATION

SAN FRANCISCO OFFICE
400 OYSTER POINT BLVD, STE 401
SOUTH SAN FRANCISCO, CA 94080

PHONE (650) 246-1440
FAX (650) 246-1441

EMAIL gpsanfrancisco@grayandprouty.com

www.grayandprouty.com

Bill K. Gray
John P. Welch, Inc.
James B. James
Melinda Schaffner, Inc.
Marilee B. Hazen
Stephen M. Berger
Malcolm D. Schick

C. Kempton Letts ^
Kelly J. Hamilton
Roger A. Cartozian
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Christopher Cooley

Gehring C. Prouty (1947 - 1998)

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David J. Mitchell
Khanh Le Kwan
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Brittany B. Huynh
Diane G. Worley
Gerald J. Bowman
Craig E. Munson
Jennifer L. Rusnak
Craig A. Kingscott

Of Counsel
James C. Hazen

* Licensed in Hawaii
** Licensed in Nevada
^ Licensed in Colorado
^^ Licensed in Washington

May 2, 2007

Mary Lou Williams, Esq.
4104 24TH Street, Suite 438
San Francisco, CA 94114

Re: Employee: Mark Antoine Foster
Employer: Aramark
WCAB#: SFO 0496875
Claim#: 300231324

Dear Ms. Williams:

Enclosed is the proposed Compromise and Release agreement which I have prepared reflecting our settlement discussions. Please note that the settlement is contingent upon Mr. Foster signing the Voluntary Resignation and also the Addendum reflecting that he is not receiving Social Security Disability nor has he filed a claim for this benefit. Once Mr. Foster has signed the enclosed documentation, would you kindly return the documents to my office and I will hand walk them through the Board and obtain an Order Approving. I recognize that I indicated I would sign these documents initially. However, I want to insure that Mr. Foster signs the Voluntary Resignation and the Medicare Information form before signing the settlement documents.

Thank you for your assistance in this matter.

Very truly yours,
GRAY & PROUTY

BY: _____
C. Kempton Letts, Esq.
ckletts@grayandprouty.com

CKL/ec
enclosures
cc: Gretchen McCoy: Specialty Risk Services

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

COMPROMISE AND RELEASE

Case No(s). SFO 0496875

Social Security No. 302-56-8205

Mark Antoine Foster Applicant (Employee)	725 Ellis Street, Apt. 408 San Francisco Ca 94109 Address
Aramark dba Bankers Club Of S.F. Correct Name(s) of Employer(s)	555 California Street, Suite 1950 San Francisco, Ca 94104 Address(es)
Specialty Risk Services Correct Name(s) of Insurance Carrier(s) Claims Administrator(s)	P.O. Box 591 Burbank, Ca 91503 Address(es)

1. The employee, born 7/14/195 , claims that he/she was employed at SAN FRANCISCO (city), CALIFORNIA (state), as a(n) Cook (occupation) by the employer(s), and claims to have sustained injury(ies) arising out of and in the course of employment:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

on CT TO 3/28/06 to PSYCHE

on _____ to _____

on _____ to _____

on _____ to _____

on _____ to _____

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 despite any language to the contrary in this document or any addendum.

Applicant/Employee: ________ WCAB No(s). ________

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph No. 7. *Any addendum duplicating this language pursuant to Sumner v WCAB, 48 CCC 369 (1983), is unnecessary and shall not be attached.*

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ ________

TEMPORARY DISABILITY INDEMNITY PAID $ ________ Weekly Rate $ ________

Period(s) Paid ________

PERMANENT DISABILITY INDEMNITY PAID $ ________ Weekly Rate $ ________

Period(s) Paid ________

TOTAL MEDICAL BILLS PAID $ ________ Total Unpaid Medical Expense to be Paid By: 5,500.00

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the **SUM OF $** ________.
The following **amounts are to be deducted** from the settlement amount:

$ – 0 – for permanent disability advances through ________ *(date)*

$ – 0 – for temporary disability indemnity overpayment, if any.

$ ________ payable to ________

$ ________ payable to ________

$ ________ payable to ________

$ ________ payable to ________

$ 500.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 5,000.00, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code §5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

DEFENDANT AGREES TO PAY, ADJUST OR LITIGATE THE EDD LIEN.
NO OTHER LIENS OF RECORD.

Applicant/Employee: Mark Antoine Foster WCAB No(s). SFO 0 ...6875

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). **ISSUES NOT INITIALED BY ALL PARTIES ARE NOT INCLUDED WITHIN THIS SETTLEMENT.**

- [initialed] earnings
- [initialed] temporary disability
- jurisdiction
- [initialed] apportionment
- employment
- [initialed] injury AOE/COE
- serious and willful misconduct
- discrimination (Labor Code §132a)
- statute of limitations
- [initialed] future medical treatment
- [initialed] other THOMAS FINDING
- other
- [initialed] permanent disability
- [initialed] self-procured medical treatment, except as provided in Paragraph 7
- [initialed] ~~vocational rehabilitation benefits~~/supplemental job displacement benefits

COMMENTS APPLICANT STIPULATES HE HAS NOT SUSTAINED ANY OTHER INJURIES, SPECIFIC OR CUMULATIVE TRAUMA, WITH THIS EMPLOYER.

Any accrued claims for Labor Code Section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the WCAB may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the WCAB may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. **WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING OR MAY BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.**

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS *OR* ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this ______ *day of* ______________ , ______ , *at* San Francisco, CA.

[signature] 5/7/07 — *Witness 1* *(Date)*

[signature] Mark Antoine Foster May 7, 2007 — *Applicant (Employee)* Mark Antoine Foster *(Date)*

[signature] 5/7/07 — *Witness 2* *(Date)*

Attorney for Applicant MARY LOU WILLIAMS, ESQ *(Date)*

Interpreter *(Date)*

Attorney for Defendant C. KEMPTON LETTS, ESQ *(Date)*

STATE OF CALIFORNIA
County of ______________________

On this ______ day of ______________ , ________ , before me, ______________________________ , a Notary Public in and for the said County and State, residing therein, duly commissioned and sworn, personally appeared ______________________________ known to me to be the person(s) whose name(s) is/are subscribed to the within Instrument, and acknowledged to me that __ he __ executed the same.

In Witness Whereof, I have hereunto set my hand and affixed my official seal the day and year in this Certificate first above written.

____
Notary Public in and for said County and State of California

CLAIMANT/BENEFICIARY NAME stipulates that he/she is:
(Check the applicable sentence below)

✓ not currently receiving Social Security Disability or Retirement benefits and is not otherwise Medicare eligible. Claimant has not applied for Social Security benefits and does not anticipate applying for benefits in the next six months.

___not currently receiving Social Security Disability or Retirement benefits but has applied for benefits and is not otherwise Medicare eligible. Claimant anticipates being Medicare eligible in 30 months from the date of the settlement

___deemed disabled by Social Security but is not currently a Medicare beneficiary but has reasonable expectation that he/she will have Medicare coverage in the next 30 months.

CLAIMANT/BENEFICIARY NAME agrees that this settlement includes payment of $0 ____ for alleged work related medical conditions and treatment and it is the sole responsibility of *CLAIMANT/BENEFICIARY NAME* to ensure that such funds are to be used for the payment of care and treatment of such work related conditions. The employee further agrees that the settlement covers any and all liens and Federal rights of recovery under the Social Security Act Section 1862(b) of the Social Security Act {42 USC Section 1395y(b)(5) and Applicable regulations found at 42 CFR Part 411 (1990) (Medicare Secondary Payer Act), and that any such lien will be paid out of the proceeds of this settlement. *CLAIMANT/BENEFICIARY NAME* further agrees to indemnify the employer and its insurer for any claim or potential claim of Medicare for payment of any lien or right of recovery as outlined above, arising out of benefits paid to or on behalf of the employee for any care or treatment provided as the result of the employee's alleged work related conditions

_____

Applicant's Name Date

VOLUNTARY RESIGNATION

I, Mark Foster, voluntarily resign my position with Aramark as of May 1, 2007

Mark Foster, Date

EXHIBIT 6

VOLUNTARY RESIGNATION

I, Mark Foster, voluntarily resign my position with Aramark as of May 1, 2007

Mark Foster. Date